Beaumont

PRE-DIABETES ASSESSMENT

GENERAL INFORMATION

NAME	DATE
ADDRESS (street, city, zip code)	
BIRTHDATE	AGE
PREFERRED PHONE NUMBER (including area code) ☐ Home ☐ Cell ☐ Work (_____)_______________	
EMAIL	
RACE ☐ Black/African American ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other __________	
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Single	

How many people live in your home with you? ______________________

Your occupation ______________________

Shift normally worked: ☐ Days ☐ Afternoons ☐ Midnights

Highest level of education completed:

☐ Grade school ☐ High school ☐ College ☐ Post-graduate ☐ Other ______________

Preferred method of learning: ☐ lecture/discussion ☐ demonstration ☐ reading ☐ film/TV ☐ hands on

Primary language spoken ______________ Primary language read______________

Do you have a history of diabetes in your family? ☐ Yes ☐ No If yes, whom? ______________

Lab results, indicate result and date:

Blood glucose ______________ HbA1c ______________

Total Cholesterol ______________ Triglycerides ______________

LDL Cholesterol______________ HDL Cholesterol ______________

Do you have any other medical conditions? Please list ______________

____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe ______________________

____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MONITORING

Do you test your blood glucose? ☐ Yes ☐ No

Name of meter ______________________ How often?______________________

Average results (the range from low to high)______________________

Do you keep a record of your results? ☐ Yes ☐ No

NUTRITION HISTORY

Height ______________ Weight ______________ Goal weight ______________

Have you had a recent weight change? ☐ No ☐ Gained ☐ Lost

How much gained or lost? ___________ pounds in the past ___________ months

Was this expected? ☐ Yes ☐ No

Do you have any of the following problems? ☐ Frequent diarrhea ☐ Constipation ☐ Reflux

☐ Trouble chewing/swallowing ☐ Other ______________________

How many average servings do you eat per day of the following:

______Fruit ______Vegetables ______Whole grains ______Legumes ______Dairy ______Protien/meat

Have you ever followed a special diet? ☐ Yes ☐ No If yes, please describe:______________________

____

How often do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Which type? ☐ Wine ☐ Beer ☐ Mixed alcoholic drinks ☐ Other ______________________

How often do you eat out in restaurants or eat fast food/take out? ______________________

What type of restaurants ______________________

Do you skip meals? (check all that apply) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

List meal and snack times and typical meals including beverages (like milk and juice) that you might have.

Time:__________ Breakfast: ______________________

____

Time:__________ Lunch:______________________

____

Time:__________ Dinner:______________________

____

Time:__________ Snacks: ______________________

____

MEDICATIONS

Please list all your medications including over the counter, herbal preparations, vitamins, and other supplements

Medication Name	Dose / Time(s) Taken	Medication Name	Dose / Time(s) Taken

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:____

HYPOGLYCEMIC REACTIONS (Low blood glucose reactions)

Have you ever had a low blood sugar reaction? ☐ Yes ☐ No

Describe your symptoms____

How frequent are your reactions?____________________________________

How do you treat a low blood sugar reactions? ______________________________

EXERCISE

Do you consider yourself: ☐ Active ☐ Sort of active ☐ Not very active

Do you exercise? ☐ Yes ☐ No If yes, please describe below:

TYPE	HOW OFTEN	HOW LONG

Do you carry sugar/food with you when you exercise? ☐ Yes ☐ No

How often do you experience hypoglycemia when you exercise? ______________________

Is your exercise/activity limited by health problems? ☐ Yes ☐ No

If yes, how? ____

HEALTH HABITS

Do you smoke or use any type of tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes (or other products) each day?____________________

Do you use nicotine vaping products? ☐ Yes ☐ No If yes, frequency____________________

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, what kind? ____________________ How often?____________________

Date of last eye exam:____________________ Date of last dental exam:____________________

Date of last influenza vaccine:____________________ Date of last foot/monofilament exam:____________________

What is your typical blood pressure reading?____________________

PSYCHOSOCIAL

When you were first told you had pre-diabetes, how did you feel about it? ____________________

____

Describe how you feel about it now?____________________

____

Does someone help with your care? ☐ Yes ☐ No

What is the hardest thing for you when dealing with pre-diabetes? ____________________

____

What are your goals for pre-diabetes education? ____________________

____

Is there anything about your culture/religion that could affect how you manage your pre-diabetes?

☐ Yes ☐ No If yes, describe: ____________________

Other comments/concerns:____________________

____

____

Patient Signature: ____________________ Date:____________________

RN/RD Signature: ____________________ ID#: ____________________ Date:____________________

Time of appointment: ____________________ Total time: ____________________